



Illinois Department of Corrections

Administrative Directive

Number:

04.04.125

Title:

Mental Health Continuous Quality Improvement Program

Effective:

10/1/2020

Authorized by:

[Original Authorized Copy on File]

Rob Jeffreys
Acting Director

Supersedes:

04.04.125 effective 7/1/2020

Authority:

730 ILCS 5/3-2-2
20 IAC 415

Related ACA Standards:

5-ACI-6A-29, 5-ACI-6C-03 and 13

Referenced Policies:

04.04.101

Referenced Forms:

I. POLICY

The Department shall require that each correctional facility, excluding Transitional Security facilities, develop and participate in a comprehensive Mental Health Continuous Quality Improvement Program that provides for the systematic, ongoing, objective monitoring, evaluation and improvement of the quality, efficiency and effectiveness of offender mental health care.

II. PROCEDURE

A. Purpose

The purpose of this directive is to establish written guidelines defining the requirements of the Mental Health Continuous Quality Improvement Program:

1. To ensure offender care is maintained and delivered in a cost-efficient, safe and appropriate manner.
2. To ensure compliance with recognized correctional community standards of care.
3. To ensure ongoing, systematic evaluation of offender care practices and services, as well as professional or clinical performance.

B. Applicability

This directive is applicable to all correctional facilities within the Department, excluding Transitional Security facilities.

C. Facility Reviews

A facility review of this directive shall be conducted at least annually.

D. Designees

Individuals specified in this directive may delegate stated responsibilities to another person or persons unless otherwise directed.

E. Definitions

Corrective Action Plan – a plan established to remediate an identified problem.

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Criteria – predetermined objective elements of patient care used to measure extent, value or quality.

Direct Service, Intervention-Based Outcome quality improvement studies – studies to examine whether expected outcomes of offender care were achieved by:

1. Identifying an offender clinical care problem (e.g. frequent self-injury, need for clinical restraints, consumer satisfaction survey for a specific intervention, etc.).
2. Conducting a baseline study.
3. Developing and implementing a clinical corrective action plan.
4. Restudying the problem to assess the effectiveness of the corrective action plan.
5. Assessing whether the action plan was sufficient to address offenders' underlying mental health problems.
6. Determining whether the nature and frequency of the action plan were sufficient to provide offenders with supportive interventions needed to manage reoccurring mental health problems.

Facility Mental Health Authority – the facility's Psychology Administrator, or in his or her absence, a mental health professional designated to make mental health decisions by the Chief Administrative Officer.

Problem – an aspect of mental health care services about which a question, concern or deficiency has been identified.

Quality Improvement Program – the process by which all mental health care services are examined through an ongoing monitoring, evaluation and improvement process to assess the quality and appropriateness of care.

System Process Analysis Quality Improvement studies – studies to examine the effectiveness of the mental health care delivery process by:

1. Identifying a facility deficiency (e.g. delayed sick-call appointments, discontinuity of medications, lack of follow-up on abnormal lab values, etc.).
2. Conducting a baseline study (e.g. task analysis, root cause, staffing plans, etc.).
3. Developing and implementing a corrective action plan.
4. Restudying the deficiency to assess the effectiveness of the corrective action plan.

Thresholds – the expected level of performance of aspects of mental health care established by the quality improvement committee.

F. Requirements

1. The Quality Oversight Committee shall be chaired by either the Chief of Mental Health, the Mental Health Continuous Quality Improvement (CQI) Manager or both. This committee shall:
 - a. Be comprised of the Chief of Psychiatry, all Regional Psychology Administrators, the Mental Health Training Coordinator, the vendor's Quality Assurance Director, Mental Health Director, Psychiatric Director and all Regional Mental Health Staff.

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- b. Meet quarterly at minimum.
 - c. Report all data collected in a table format that allows for comparison to the previous quarter's data.
 - d. Keep all meetings, discussions and activities documented confidential.
 - e. Make recommendations for essential service delivery improvements which shall be immediately communicated to all applicable staff.
 - f. Routinely review the regional or grouped data on major occurrences related to mental health issues including suicides, suicide attempts requiring off-site medical care, use of emergency enforced medication and use of restraints for mental health purposes.
 - g. Review mental health policies, procedures, resource allocations, department wide studies and innovative initiatives.
 - h. Review each facility's Annual CQI plan and provide feedback to the facility on results which may include further corrective action directives.
2. The Chief Administrative Officer (CAO) shall designate a Facility CQI Committee. This committee shall:
- a. Be chaired by the facility Mental Health Authority.
 - b. Be comprised of the facility's Assistant CAO of Programs, the Regional Mental Health Psychologist Administrator, the Health Care Unit Administrator, the Director of Nursing, the Medical Director and a representative from each of the following disciplines: psychiatry, clinical psychology, social worker, mental health nursing and mental health professionals. The Regional Medical Administrator and any other facility staff may participate at the discretion of the CAO.
 - c. Meet on a monthly basis. All collected and reported data shall be in a table format that allows for comparison to the previous 12 months.
 - d. Keep all meetings, discussions and activities documented confidential.
 - e. Send a summary to the CAO and any recommendations for essential services delivery improvements shall be immediately communicated to all applicable staff.
 - f. Routinely review, and improve major occurrences related to mental health delivery services including suicides, suicide attempts requiring off-site medical care, use of emergency enforced medication, implementation and discontinuation processes for use of restraints for mental health purposes, and any other high risk or high-volume activities.
 - g. Additional criteria for quality improvement studies and threshold levels shall be outlined in the Mental Health Standard Operating Procedural Manual as required in Administrative Directive 04.04.101.
 - h. Be structured by an agenda that includes:
 - (1) Review of mental health service delivery statistics and trends;

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NOTE: The Office of Mental Health Management shall develop a format for reporting mental health service delivery statistics. The statistics shall be reported monthly and trended over time by the Facility CQI Committee and the Quality Oversight Committee.

- (2) Review of psychotropic medication and non-formulary medication usage;
 - (3) Review of Major Mental Health Occurrence reports and related recommendations, including serious suicide attempts and morality reviews;
 - (4) Review of offender grievance reports related to mental health;
 - (5) Review of progress on action plans related to prior CQI activities;
 - (6) Discussion about the annual CQI project, including development of recommendation for improvement;
 - (7) Discussion about implementing CQI projects for the coming year, including assigning staff responsibilities;
 - (8) Discussion about issues appropriate for consideration by the CQI Committee; and
 - (9) Other business, as necessary.
3. The Facility Mental Health Authority and the Assistant CAO of Programs shall develop an annual CQI plan for the facility. The plan shall:
- a. Establish and develop monitoring tools for a specific type of documentation, or an aspect of care to be evaluated during each quarter.
 - b. Include at least two System Process Analysis Improvement studies and at least two Direct Service Intervention-Based quality improvement studies a year, in which a deficiency or a service outcome is identified, a study is completed and a plan is developed and implemented. The four steps to complete the Direct Service Intervention-Based and System Process Analysis found on the doc0577 shall include the following:
 - (1) Plan – The Plan step entails identifying specific, measurable and achievable goal(s), formulating a plan of action and developing a data collection method
 - (2) Do – The Do step is the implementation of the strategies developed in the Plan
 - (3) Study – The Study step focuses on looking at benchmark(s), analyzing the data, noting trends, and determining if changes are warranted in order to meet standards.
 - (4) Act – The Act Step reflects on the plan and outcomes. This step also implements and evaluates changes.
 - c. Include an annual review of the effectiveness of the CQI program through review of CQI studies and minutes from the CQI Committee, administrative or staff meetings and other pertinent written materials.

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- d. Monitor and track results. All studies which result in the desired threshold not being met will be repeated until the Facility CQI Committee determines otherwise.
 4. Minutes of both the Facility CQI Committee and the Quality Oversight Committee meetings shall be completed and reviewed for accuracy at the following meeting.
 5. CQI documents are confidential and may not be disclosed to any person or entity except as provided by specific legal exemptions. Documentation of internal review activities must comply with legal requirements. All CQI documentation shall be marked as "Confidential".
 6. CQI documents shall be maintained in a confidential, secured manner, under the control of the facility mental health authority. All listed documentation shall be retained in accordance with record retention. Any documentation may be retained for longer periods of time if such retention is deemed necessary.
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